Vision Care Plan Highlights

The Vision Care Plan covers an annual eye examination to assess your visual functions and prescribe corrective eyewear when needed.

Plan Provisions and Copayments

The Vision Care Plan provides for a new pair of lenses and frames each year. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames until the following Plan Year.

Covered Services Overview

Covered Services	In-Network *Plan Pays*	Out-of-Network *Plan Pays*
Benefit Maximum	$1,000 every 2 years (excludes Copayments)	
Exam[1]	100% after $10 Copayment	Up to $35
Lenses and Frame[1]		
Single vision lenses	100% after $20 *Copayment*[2] (*retail allowance of* $130 on covered frames and 20% discount on out-of-pocket expenses)	Up to $25
Bifocal lenses		Up to $40
Trifocal lenses		Up to $55
Lenticular Lenses		Up to $80
Frames		Up to $45
Contact Lenses[3]		
Elective	Up to $120/year	Up to $105
Non-elective	100% after $20 Copayment[4]	Up to $210

[1] One examination and either lenses and/or frames or contact lenses are covered under the Vision Care Plan each Plan Year.
[2] Only one $20 Copayment applies to lenses and/or frame per Plan Year.
[3] If you choose contacts, you will be eligible for lenses and frames in the next Plan Year.
[4] Approved by doctor with preauthorization.

Covered Services and Supplies

- **Eye Exam** – a complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
- **Lenses** – the VSP network doctor orders the proper lenses necessary for your visual welfare and verifies the accuracy of the finished lenses.
- **Frames** – the VSP network doctor assists in the selection of frames, properly fits and adjusts the frames and provides subsequent adjustment to frames to maintain comfort and efficiency. VSP's frame benefit covers over half of the frames available. When deciding on a frame, you should ask your doctor which ones are fully covered under the Plan.
- **Contact Lenses** – provided in lieu of spectacle lenses and frames for the Plan Year. The $120 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

Hourly Associate Payment Schedule

Years of Service	# of Weeks at 75% of Pay	# of Weeks at 50% of Pay	Total Eligible Weeks
Less than 1 year	0	0	0
1	1	1	2
2	2	3	5
3	4	5	9
4	5	7	12
5	6	9	15
6	6	11	17
7	7	13	20
8	8	15	23
9	9	16	25
10 – 15	10	15	25
16 – 20	15	10	25
20+	20	5	25

Note: The first five days (or first four days, if your regular work schedule is four 10-hour days per week) are covered under the Company's Paid Time Off (PTO) Plan for Hourly Associates. If you do not have any or enough accrued PTO, the absences will be unpaid.

Salaried Associate Payment Schedule

Years of Service	# of Weeks at 100% of Pay	# of Weeks at 75% of Pay	# of Weeks at 50% of Pay	Total Eligible Weeks
Less than 1 year	2	1	0	3
1	8	1	4	13
2	9	2	4	15
3	10	3	5	18
4	13	4	3	20
5	13	5	8	26
6	13	6	7	26
7	13	7	6	26
8	13	8	5	26
9	13	9	4	26
10 – 15	13	10	3	26
16 – 20	13	13	0	26
20+	26	0	0	26

Continuing Your Other Group Benefits

Your coverage under the Medical, Dental Care, Vision Care, Health Care and Dependent Care Spending Accounts, as well as Long Term Disability and Life Insurance Plans will continue for the first six months of your STD leave, as long as you remain eligible. After the sixth month, you may continue your Medical, Dental Care, Vision Care and Health Care Spending Account coverage as provided by COBRA, and you may be eligible to continue your Life Insurance Plan coverage at no cost to you through the Life Insurance Premium Waiver.

If you return to work after being on leave for six months or more, you must re-enroll in the benefit plans within 30 days of your return to work date. Benefits will become effective the first of the month after you return to work provided you have re-enrolled. If you do not re-enroll, you will have to wait until the next annual enrollment period to make your benefit elections.

Refer to each Plan's section within this Summary Plan Description and/or the Associate Leave Standard Operating Policy for specific information about continued coverage during a leave of absence.

Payments

When Benefits Begin

If you are eligible to receive STD payments and you are a Salaried Associate, your STD payments will be retroactive to the first day of absence due to a Medical Condition as certified by a Medical Doctor. For all other types of Associates who are eligible to receive STD payments, payments will begin on the sixth consecutive scheduled workday of absence due to a Medical Condition as certified by a Medical Doctor.

Determining Your Benefits

Several factors are taken into account when determining the amount of STD payments you may be eligible for. The maximum payment you may be eligible to receive depends on your Years of Service and your weekly Earnings.

- Years of Service are the completed number of years you worked for the Company as of your initial date of absence for the Medical Condition that caused you to request an STD leave of absence.
- Weekly Earnings depend on your position with the Company.

Use the following table to calculate your weekly Earnings and apply that calculation to the Benefits Schedule to determine an estimated amount for your STD payments.

Weekly Earnings

For the purpose of calculating your weekly Earnings, Earnings include your gross base pay before any deductions. Earnings do not include overtime, special allowances, bonuses, stock-related income, tuition reimbursements, meal allowances, or any other extra compensation or income received from sources other than the Company.

Type of Associates	Weekly Earnings
Salaried	Base annual salary / 52
Full-time Hourly	Current hourly rate x 40

The payment schedules take into account your Years of Service and your position to determine how long and what percentage of your weekly Earnings will be paid to you for Short Term Disability.

Short Term Disability Plan

Associate Service Center
(800) 288-6353

This section describes the provisions of the Short Term Disability (STD) Plan and Company policy governing absences due to Medical Conditions, including those due to job-related Illnesses or Injuries. The STD Plan may provide payments in the event you are disabled and eligible for benefits. This Summary Plan Description acts as the Plan Document for the STD Plan, and will supersede any earlier versions of the Plan Document. The STD Plan is self-funded and administered by Hewitt Associates as directed by Circuit City Stores, Inc.

Eligibility and Enrollment

All Associates are eligible for leave upon date of hire; however, may not be eligible for pay. Eligibility for pay varies based on status and length of service.

Associate Eligibility for STD Pay

- Regular Full-time Salaried Associates are eligible for paid coverage under this Plan on their date of hire according to the chart on page 109.
- Regular Full-time Hourly Associates are eligible for paid coverage under this Plan on their one year anniversary date.

How and When to Enroll

Enrollment is not necessary under this Plan. You are automatically enrolled when you become eligible; however, completed forms are required to process the leave and pay (if eligible).

Absences Due to Illness or Injury

Any time you will be out of work because of a Medical Condition, work-related or non-work-related, including pregnancy, you must contact your manager to notify her/him of your absence. If you will be out of work for more than five consecutive scheduled workdays, you must also notify the Associate Service Center and provide Medical Certification of your Illness or Injury from your doctor. If you are eligible for STD pay and/or Workers' Compensation payments, you must also complete an Authorization to Release Protected Health Information form before pay will be released.

To obtain Medical Certification and Authorization to Release Protected Health Information forms, visit www.mycircuitcityhr.com or call the Associate Service Center at (800) 288-6353.

It is very important to maintain contact with your manager and the Associate Service Center during your Short Term Disability leave, even if you are not receiving payments under the Plan. Medical Certifications must be kept up to date to inform the Associate Service Center of the length of your absence, your diagnosis and when your doctor expects you to return to work. Failure to report absences to your manager and the Associate Service Center may result in termination of your employment with the Company.

Claims and Appeals Review

The Plan will review your claim and make a decision within the allowable timeframe listed below.

- *Your Spending Account* will notify you within 90 days of any denial or send written notice for a 90-day extension.
- The initial claim review cannot exceed 180 days.
- You will have 60 days following receipt of denial to request an appeal.
- Circuit City must make a decision on the appeal within 60 days or send written notice for a 60-day extension.
- The appeals review cannot exceed 120 days.

When Participation Ends

Your participation in the DCSA Plan will end on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- When required contributions stop being made
- When your election to participate in the Plan terminates (each February 28/29 unless you re-enroll at annual enrollment)
- When the Plan ends

If your participation in the DCSA Plan ends for any of the above reasons, you will generally have 90 days following the end of the Plan Year to submit claims for reimbursement, but only for expenses incurred prior to the termination of your participation.

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Dependent Care Spending Account Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you are on Military Leave, you may elect to continue your active coverage for up to twelve months.

You may not change, drop or add to your Dependent Care Spending Account benefit during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

Mail or fax your claim to:

Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
Fax #: (888) 211-9900

Maximum Reimbursement

The maximum reimbursement is limited to the balance in your account at the time you submit the request for reimbursement. For example, if you have a balance of $200 in your account and you submit a claim for $300 in eligible expenses, you will receive reimbursement of only the first $200 of eligible expenses. You should not consider this partial reimbursement as a denied claim. You will receive reimbursement for the remaining $100 as soon as you have made additional contributions to your account to cover the additional expenses. You do not need to re-submit a claim in this case; payment will be made to you automatically when your account balance reaches a sufficient level to cover your previous reimbursement request.

Payment of Reimbursement Requests

During the Plan Year, as you incur eligible expenses, you can submit claims for reimbursement to *Your Spending Account*. You will receive reimbursement for eligible expenses up to the amount you have set aside out of your paycheck.

Claims are processed on a daily basis and you should receive reimbursement as soon as administratively possible, and no later than 30 days after *Your Spending Account* receives your paperwork. For faster processing, fax your signed and completed claim form and supporting documentation to *Your Spending Account* at (888) 211-9900 and sign up for direct deposit. With direct deposit you don't have to wait for a check to be delivered and take time out of your day to go to the bank.

Filing an Appeal

You have the right to appeal any denied claim. If a portion of or your entire claim is not eligible for reimbursement, you will receive notification from *Your Spending Account*. If you are not satisfied with the determination, please call (800) 350-0580. If, after investigation, it is determined that the claim (or a portion of it) was correctly denied, you may appeal the denial in writing to the Plan administrator. The Associate Service Center will provide you with a claim form that you can mail or fax to:

Circuit City Stores, Inc.
P.O. Box 563986
Charlotte, NC 28256-3986
Fax #: (281) 298-0844

Note: The Enrollment Request form can also be used to file your appeal. The Enrollment Request form can be found on *My Circuit City Benefits*.

You must submit your appeal within 60 days from receipt of the denial or you waive your right to request a review of the denied claim.

Refer to the "Claims" section at the beginning of this booklet for additional information about denied claims and what to expect from the Plan.

Facilities that provide care for more than six individuals not residing at the facility must comply with all applicable state and local laws and regulations. For proper reimbursement of expenses incurred through a Dependent's care provider, obtain the provider's Social Security number or Federal Taxpayer ID number for income tax reporting purposes and an itemized receipt with the dates of service.

Exclusions

Examples of expenses that are not eligible for reimbursement through a DCSA include, but are not limited to:

- Medical care
- Dependent care provided by your own child under age 19 or another Dependent
- Dependent care used for non-work-related reasons
- Overnight camp
- Kindergarten fees or private school tuition
- Dependent care expenses incurred while your spouse does not work, unless your spouse is a full-time student or is disabled
- Expenses paid by another organization or provided without cost
- Transportation to and from the Dependent care location provided by someone other than the caregiver
- Care provided in a nursing home
- Care provided in a group care center that does not meet the requirements of state and local laws
- Costs for clothing, entertainment or food
- Expenses incurred by a non-custodial parent, even if the non-custodial parent claims the child as a Dependent for income tax purposes
- Expenses incurred before your eligibility date or before the applicable Plan Year
- Expenses incurred after the applicable Plan Year

For more information about reimbursable expenses and coverage, go to www.mycircuitcityhr.com, then *My Circuit City Benefits* and select *Your Spending Account* or call (800) 288-6353.

Claims Reimbursement

Filing a Claim for Reimbursement

When you submit your claim for reimbursement, include the itemized receipt from the Dependent care provider and the provider's Social Security number or Federal Tax ID number. Handwritten documentation, canceled checks and online bank statements will not be accepted.

Dependent care claims will only be reimbursed if the service has already been completed. If a claim includes future dates of service, the claim will be denied unless the claim documentation is itemized, in which case the claim will be partially approved up to the date it is being processed.

You must submit all claims for a Plan Year by May 31 (90 days following the end of the Plan Year).

After the 90-day period expires, IRS regulations require any remaining balance in your account to be forfeited, otherwise known as, "use it or lose it."

Tax Reporting Requirements

Although you do not pay federal income tax or Social Security on your DCSA contributions, your total contributions will be recorded in a separate box on your Form W-2. When you file your income taxes, complete and file an IRS Form 2441 or Schedule 2 to identify Dependent care reimbursements and to calculate any expense which may remain eligible for the IRS Dependent Care Tax Credit. Form 2441 and Schedule 2 require that you report the name, address and Federal Taxpayer ID number of your Dependent care provider(s). Use Form W-10 to request this information from the Dependent care provider and retain the form for your records. Form W-10 does not need to be filed with any government agency.

Child and Dependent Care Tax Credit

When you file your income taxes, you may qualify for the IRS tax credit for Dependent care expenses. The tax credit, which directly offsets the income taxes you must pay, is based on a percentage of your eligible Dependent care expenses up to $3,000 for one Dependent or up to $6,000 for two or more Dependents. The amount of Dependent care expenses for which you may receive the tax credit is reduced, dollar for dollar, by the amount you were reimbursed from your DCSA. In other words, you cannot claim both the tax credit and reimbursement from the DCSA for the same expenses. Therefore, you should carefully consider whether it is more advantageous for you to participate in the DCSA or to claim the full IRS tax credit, if you qualify.

The amount of the tax credit for which you are eligible is based on various factors, including your income, filing status, and eligible expenses. For additional information about the IRS tax credit for Dependent care expenses, refer to IRS Publication 503 "Child and Dependent Care Expenses" or consult with your personal financial or tax advisor.

Call the Associate Service Center at (800) 288-6353 with any questions about contributions or deductions.

Coverage

DCSA Participants may receive reimbursement each Plan Year for certain eligible Dependent care expenses that are incurred during that Plan Year (after your effective date of participation).

Eligible Expenses

Dependent care expenses are eligible for reimbursement only if the expense is incurred so that you may work or actively look for work. If you are married, your spouse also must work or be actively looking for work, unless she/he is disabled or a full-time student at least five months during the year while you are working.

Examples of eligible expenses that may be reimbursed through the DCSA Plan include, but are not limited to, the following:

- A qualified day care provider, in the home or outside of the home
- A babysitter, au pair, nanny, or neighbor who watches your Dependent
- Summer day camp, if the primary purpose of sending the child to day camp is day care
- Before and after school programs whose primary function is to watch your child until you return home
- Preschool tuition

If expenses are incurred for services outside your home, and they are incurred for the care of a disabled Dependent, they will be covered under the Plan only if the Dependent regularly spends at least eight hours per day in your home.

persons who must have constant attention to prevent them from injuring themselves or others are considered unable to care for themselves.

How and When to Enroll

- If you are a Regular Full-time Associate, you must complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change
- If you are a Regular Part-time Associate, you must complete the on-line enrollment process within 30 days prior to your eligibility date, during annual enrollment or upon/after a Qualified Family Status Change

Call the Associate Service Center at (800) 288-8353 for questions about eligibility and enrollment.

Contributions

Contributions to your DCSA are deducted from your paycheck after any other Pre-tax Contributions, except your contributions to the 401(k) Plan. If the amount of money left in your paycheck after other Pre-tax Contributions have been deducted is less than your elected DCSA Plan contribution, then your contribution for that pay period will be reduced to what is left in the paycheck. No contributions or partial contributions are held over from one pay period to the next. Your DCSA Plan contribution will be reduced or not deducted from your paycheck if, by deducting the contribution, the amount remaining in your paycheck is not enough to pay after-tax deductions.

The DCSA Plan is subject to non-discrimination testing. If you are a "Highly Compensated Employee," as defined by the IRS, your election may be reduced as needed for the Plan to pass the non-discrimination test. You will be notified if this occurs.

Determining Your Contribution Amount

When you enroll in the Plan, you determine how much to contribute. Because of the limitations on spending and contributions, you will want to carefully estimate your expenses. Consider the following rules when you determine your contribution elections:

- The minimum amount you can contribute per Plan Year is $100 and the maximum amount is $5,000.
- The amount you elect to contribute cannot be changed during the Plan Year, unless you experience a Qualified Family Status Change.
- Contributions made during a Plan Year can only be used to pay for eligible expenses incurred during that Plan Year.
- Any amount in your DCSA at the end of the Plan Year cannot be carried over to the next Plan Year and is forfeited.
- Based on Internal Revenue Code, the maximum amount you can contribute during a taxable year is the lesser of the following amounts, depending on your filing status:

If you are single, you may only contribute up to the lesser of:	If you are married, you may only contribute up to the lesser of:
– $5,000; or – Your earned income for the taxable year	– $5,000 if filing jointly; or – $2,500 if filing separately (even if your spouse does not contribute to a DCSA); or – Your earned income for the taxable year; or – Your spouse's earned income for the taxable year. (If your spouse is disabled, her/his earned income is calculated with $250 a month if you have one Dependent, or $500 a month if you have two or more Dependents.)
Restrictions: The combined total for you and your spouse's contributions cannot exceed $5,000.	

Dependent Care Spending Account Plan

Your Spending Account DCSA

Your Spending Account
(800) 288-6353
www.mycircuitcityhr.com, then My Circuit City Benefits and select Your Spending Account

The Dependent Care Spending Account (DCSA) is a convenient way to set aside part of your income on a pre-tax basis to pay for certain eligible Dependent care expenses, including child care and elder care services. The DCSA is self-funded through Circuit City Stores, Inc. and is administered through a contract with Hewitt Associates' *Your Spending Account*. For specific information about eligibility and enrollment, refer to the "Eligibility and Enrollment" section at the beginning of this booklet.

The Dependent Care Spending Account is not for reimbursable health care expenses.

Eligibility and Enrollment

Associate Eligibility

- Regular Full-time Associates are eligible for coverage under this Plan the first of the month after completing one calendar month of service.
- Regular Part-time Associates are eligible for coverage under this Plan the first of the month after completing one year of continuous service.
- To be eligible for the Plan, you must be a single parent or married/domestic partnership where both individuals are working, or your partner is actively seeking work. If one of the partners is disabled or a full-time student for at least five months during the year, you may also be eligible for the Plan.

***Special Note for Part-time Associates:* If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.**

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. The form must be completed and approved before the enrollment will be processed. If your claim initiation/appeal to add coverage after the eligibility timeframe is approved, your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

Dependent Eligibility

Only expenses incurred on behalf of an eligible Dependent who is a member of your household qualify for reimbursement under the DCSA Plan. An eligible Dependent can be any of the following:

- A child under the age of 13 whom you are entitled to claim as a Dependent on your federal income tax return, even if you do not in fact claim the child as a Dependent for income tax purposes;
- Any other Dependent who is disabled* regardless of age; or
- A disabled* spouse

**A disabled Dependent or spouse is someone who is physically or mentally unable to care for him/herself. Persons who cannot dress, clean or feed themselves because of physical or mental problems are considered unable to care for themselves. Also,*

If your participation in the HCSA Plan ends for any of the above reasons, you will generally have 90 days following the end of the Plan Year to submit claims for reimbursement, but only for expenses incurred prior to the termination of your participation.

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Health Care Spending Account Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you do not return from leave after six months, you may elect to continue your coverage to the extent required under COBRA. If you are on Military Leave, you may elect to continue your active coverage for up to twelve months and may then continue coverage to the extent required under COBRA (see Associate Leave Standard Operating Policy for details).

You may not change, drop or add to your Health Care Spending Account benefit during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

COBRA

If coverage for you and/or your Dependents ends, eligibility to continue coverage under COBRA may apply. This optional continuation of group health care coverage is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Explanation of Benefits

Each time a reimbursement request is processed, you will receive an Explanation of Benefits (EOB) in the mail or an email notification of your claim status if you have provided an email address through the *Your Spending Account* website. The EOB explains how much was paid for each reimbursement request. The EOB includes the amount requested from the form submitted to *Your Spending Account*, the amount reimbursed, the amount denied (if any), and the amount reimbursed year-to-date.

Filing an Appeal

You have the right to appeal any denied claim. If a portion of or your entire claim is not eligible for reimbursement, you will receive notification from *Your Spending Account*. If you are not satisfied with the determination, please call (800) 288-6353. If, after investigation, it is determined that the claim (or a portion of it) was correctly denied, you may appeal the denial in writing to the Plan administrator. The Associate Service Center will provide you with a claim form that you can mail or fax to:

Circuit City Stores, Inc.
P.O. Box 563986
Charlotte, NC 28256-3986
Fax #: (281) 298-0844

Note: The Enrollment Request form can also be used to file your appeal. The Enrollment Request form can be found on *My Circuit City Benefits*.

You must submit your appeal within 60 days from receipt of the denial or you waive your right to request a review of the denied claim.

Refer to the "Claims" section at the beginning of this booklet for additional information about denied claims and what to expect from the Plan.

Claims and Appeals Review

The Plan will review your claim and make a decision within the allowable timeframe listed below.

- *Your Spending Account* will notify you within 90 days of any denial or send written notice for a 90-day extension.
- The initial claim review cannot exceed 180 days.
- You will have 60 days following receipt of denial to request an appeal.
- Circuit City must make a decision on the appeal within 60 days or send written notice for a 60-day extension.
- The appeals review cannot exceed 120 days.

When Participation Ends

Your participation in the HCSA Plan will end on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- When required contributions stop being made
- When your election to participate in the Plan terminates (each February 28/29 unless you re-enroll at annual enrollment)
- When the Plan ends

- Weight-loss treatments, unless prescribed by a Physician to treat a specific Illness
- Long-term care expenses
- Health care expenses that are reimbursable under any other health plan or insurance

For more information about reimbursable expenses and coverage, go to www.mycircuitcityhr.com, then *My Circuit City Benefits* and select *Your Spending Account* or call (800) 288-6353.

Claims Reimbursement

Filing a Claim for Reimbursement

When you submit your claim for reimbursement, include the itemized receipt from the Health Care Provider or other documentation such as an Explanation of Benefits (EOB) from the health plan or store receipts. If you submit a claim without itemized documentation, you will be required to provide alternate information (i.e. copy of the package from an over-the-counter item, etc.). Handwritten documentation, canceled checks and online bank statements will not be accepted.

A statement of medical necessity is required for items that serve more than one purpose (i.e., vitamins, herbal remedies, nutritional supplements, massage therapy, etc.).

You must submit all claims for a Plan Year by May 31 (90 days following the end of the Plan Year).

After the 90-day period expires, IRS regulations require any remaining balance in your account to be forfeited, otherwise known as, the "use it or lose it" rule.

Mail or fax your claim to:

Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
Fax #: (888) 211-9900

Maximum Reimbursement

The maximum reimbursement is limited to your Plan Year election amount.

Payment of Reimbursement Requests

During the Plan Year, as you incur eligible expenses, you can submit claims for reimbursement to *Your Spending Account*. You will receive reimbursement for eligible expenses up to the amount of your annual election.

Claims are processed on a daily basis and you should receive reimbursement as soon as administratively possible, and no later than 30 days after *Your Spending Account* receives your paperwork. For faster processing, fax your signed and completed claim form and supporting documentation to *Your Spending Account* at (888) 211-9900. You can also sign up for direct deposit at www.mycircuitcityhr.com, then:

- Select *My Circuit City Benefits* and click on *Your Spending Account*;
- Go to "Manage Account"; and
- Select "Your Preferences" tab

With direct deposit you don't have to wait for a check to be delivered and take time out of your day to go to the bank.

Coverage

HCSA Participants may receive reimbursement each Plan Year for certain eligible health care expenses that are incurred during that Plan Year (after your effective date of participation). The HCSA is for eligible health care expenses that are not paid by any medical, dental or vision plan in which you are currently enrolled. You may contribute a minimum of $100 and a maximum of $5,000 to your HCSA.

Eligible Expenses

Only expenses that are not paid by a medical, dental or vision plan and are incurred during the Plan Year can be reimbursed. **For a complete listing of eligible expenses, go to www.mycircuitcityhr.com, then *My Circuit City Benefits* and select *Your Spending Account*.**

Examples of eligible expenses that may be reimbursed through a HCSA include, but are not limited to, the following:

- Deductibles
- Copayments
- Coinsurance
- Charges in excess of Reasonable and Customary limits
- Prescription drugs and medicines
- Charges for services and supplies not covered by a medical, dental or vision plan
- Charges in excess of annual plan limits
- Eye examinations and treatment, including LASIK surgery
- The cost of eyeglasses, contact lenses and prescription sunglasses
- The cost of hearing aids and batteries
- Prepaid orthodontia treatment
- Over-the-counter drugs and other items use for diagnosis, cure, easing pain or ailment, treatment and prevention of disease, including allergy medications, antacids, and pain relievers
- Long-term care premiums

Continuation Rights

If your participation in the HCSA ends, eligibility to continue participation under COBRA may apply. This optional continuation is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Exclusions

Examples of expenses not eligible for reimbursement through an HCSA include, but are not limited to, the following:

- Medical plan premium payments
- Health club fees
- Dietary supplements
- Disability and life insurance premium payments
- Living expenses
- Cosmetics
- Cosmetic surgery, unless it is for the treatment of a disfiguring illness or injury
- Cosmetic dental procedures, such as bleaching
- Over-the-counter vitamins, drugs and items used for general good health and cosmetic purposes

Contributions

Contributions to your HCSA are deducted from your paycheck after any other Pre-tax Contributions, except your contributions to the 401(k) Plan. If the amount of money left in your paycheck after the other Pre-tax Contributions have been deducted is less than your elected HCSA Plan contributions, then your contribution for that pay period will be reduced to what is left in the paycheck. Your HCSA Plan contribution will be reduced from your paycheck and the remaining will go into arrears.

Determining Your Contribution Amount

When you enroll in the Plan, you determine how much to contribute. Because of the limitations on spending and contributions, you will want to carefully estimate your expenses. Consider the following rules when you determine your contribution elections:

- The minimum amount that you can contribute per Plan Year is $100 and the maximum amount is $5,000.
- For mid-year enrollment, the amount you select to contribute will be divided over the remaining pay periods for the Plan Year to determine the contributions deducted from your paycheck.
- The amount you elect to contribute cannot be changed during the Plan Year, unless you experience a Qualified Family Status Change.
- Contributions made during a Plan Year can only be used to pay for eligible expenses incurred during that Plan Year.
- Any amount left in your HCSA at the end of the Plan Year is forfeited and cannot be carried over to the next Plan Year.

Contributions During a Leave of Absence

You may not change, drop or add to your Health Care Spending Account benefit during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

As long as you continue your participation in the Plan during your leave, health care expenses incurred during the leave are eligible for reimbursement.

Tax Reporting Requirements

Although you do not pay federal income tax or Social Security on your HCSA contributions, your total contributions will be recorded in a separate box on your Form W-2. Under current IRS regulations, you can only deduct from your income tax any eligible health care expenses exceeding 7.5% of your adjusted gross income, provided you are itemizing deductions. However, when you receive reimbursement from a HCSA for these expenses, the entire amount you put into the HCSA is deducted from your taxable income even if you do not itemize deductions. Therefore, you have to choose whether you want to take the itemized tax deduction or use the HCSA.

Generally, if you do not itemize your tax deductions or if your health care expenses are less than 7.5% of your adjusted gross income, it may be more beneficial to participate in a HCSA. Consult a tax advisor to determine what is best for your situation.

Call the Associate Service Center at (800) 288-6353 with any questions about contributions or deductions.

Health Care Spending Account Plan

Your Spending Account HCSA

Your Spending Account
(800) 288-6353
www.mycircuitcityhr.com, then My Circuit City Benefits and select Your Spending Account

The Health Care Spending Account (HCSA) is a convenient way to set aside income on a pre-tax basis to pay for certain eligible health care expenses. These expenses include, but are limited to, medical, dental, vision, over-the-counter drug and other expenses defined by the Internal Revenue Service. The HCSA is self-funded through Circuit City Stores, Inc. and is administered through a contract with Hewitt Associates' *Your Spending Account*. For specific information about eligibility and enrollment, refer to the "Eligibility and Enrollment" section at the beginning of this booklet.

Eligibility and Enrollment

Associate Eligibility

- Regular Full-time Associates are eligible for coverage under this Plan the first of the month after completing one calendar month of service.
- *Regular Part-time Associates are eligible for coverage under this Plan the first of the month after completing one* year of continuous service.

Special Note for Part-time Associates: If you do not work enough hours to pay for your bi-weekly deductions for two consecutive pay cycles, your coverage will be dropped.

If you want to enroll after the eligibility timeframes, contact the Associate Service Center and ask for an Enrollment Request Form. *The form must be completed before your enrollment request will be considered. If your claim initiation/appeal to add coverage after the eligibility timeframe is approved,* your benefit deductions will be taken on an after-tax basis for the remainder of the Plan Year.

Dependent Eligibility

You can use your HCSA to pay eligible health care expenses for yourself and your eligible Dependents, including your spouse, eligible Dependent children and domestic partner.

How and When to Enroll

- If you are a Regular Full-time Associate, you must complete the on-line enrollment process within 30 days after your date of hire, during annual enrollment or upon/after a Qualified Family Status Change
- If you are a Regular Part-time Associate, you must complete the on-line enrollment process within 30 days prior to your eligibility date, during annual enrollment or upon/after a Qualified Family Status Change

Call the Associate Service Center at (800) 288-6353 for questions about eligibility and enrollment.

- When required contributions stop being made
- When the Dependent becomes covered as an Associate under this Plan or another plan*
- For a spouse, the last day of the month of divorce or annulment*

**It is the Associate's responsibility to notify the Associate Service Center of these events.*

If the Associate dies while covered, eligible Dependents' coverage will continue under COBRA for up to three months after death at no cost to the family.

Continuation of Coverage during a Leave of Absence

Continuation of Coverage during a Leave of Absence

According to the Company's Associate Leave Standard Operating Policy, while you are on a leave of absence, your Vision Care Plan benefits will continue for the first six months of your leave as long as you remain eligible. If you do not return from leave after six months, you may elect to continue your coverage under COBRA for an additional 18 months. If you are on Military Leave, you may elect to continue your active coverage up to twelve months at the same cost as active associates and may then continue coverage at the cost provided under COBRA for an additional 18 months (see Associate Leave Standard Operating Policy for details).

You may not change, drop or add vision coverage during a leave of absence, unless you experience a Qualified Family Status Change. Then you must follow the guidelines for changing coverage depending on the type of event. Refer to the "Qualified Family Status Change" section at the beginning of this booklet for more information.

If you become eligible to participate in the Plan while you are on a medical leave of absence, you must still enroll within the applicable enrollment periods. Effective dates will also be the same as if you were actively working. If you fail to enroll within the applicable enrollment periods, then you must wait until the next annual enrollment unless you experience a Qualified Family Status Change or an event that qualifies for special enrollment.

COBRA

If coverage for you and/or your Dependents ends, eligibility to continue group coverage under COBRA may apply. This optional continuation of group health care coverage is available as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the "Continuation of Coverage" section at the beginning of this booklet for more information.

Reductions will equal the amount the Plan paid in excess of the amount it should have paid. In the case of recovery from a source other than this Plan, the refund will equal the amount of recovery up to the amount paid under this Plan. The Plan may have other rights in addition to the right to reduce future benefits.

Subrogation

Subrogation is a cost-containment feature that shifts the expense of treating accidental injuries back to the party or insurer properly responsible for those costs. When the Plan pays for accidental injuries, subrogation allows the Plan to recover, by legal action if necessary, those payments directly from the responsible third party.

Subrogation will result in savings to the Plan for the benefit of all Participants because the cost of treatment for sickness or Injury will be paid by the person who is legally responsible for such payment. The Plan is also subrogated and has a right of subrogation to any underinsured, insured, uninsured or any other insurance plan under which Participants are covered.

Any settlement which releases all the claims Participants have against any of the parties noted above is deemed to be for damages on account of the expenses incurred as a result of the Injury or Injuries, no matter how the settlement documents may denominate the settlement and regardless of whether the injured Participant is fully compensated ("made whole"). The Plan's recovery shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

Under this subrogation provision, Participants have the following obligations:

- To seek recovery from a third party (or her/his insurance) of all amounts in connection with Plan benefits provided, arranged or paid, and to notify the Plan within 10 working days of any such action taken by him/her.
- To refrain from doing anything to impair, prejudice or discharge the Plan's right of subrogation.
- To assist the Plan as necessary to enforce its right of subrogation.
- To pay the Plan any amounts received to the extent of benefits provided by the Plan to which the Plan is entitled because of its right of subrogation.
- To provide in a timely fashion, information requested by the Plan.

When Coverage Ends

Associate Coverage

Unless otherwise specified in this SPD, Associate coverage ends on the earliest of the following:

- The last day of the month in which your employment ends, including retirement
- The last day of the month in which eligibility stops
- The last day of the month in which you become covered under another plan (once you notify the Associate Service Center)
- When required contributions stop being made
- When the Plan ends

Dependent Coverage

Unless otherwise specified in this SPD, Dependent coverage ends on the earliest of the following:

- The last day of the month in which eligibility ends for you
- The last day of the month in which a Dependent no longer meets the definition of an eligible Dependent*
- The last day of the month in which coverage ends

to present materials or arguments. The determination of VSP, including specific reasons for the decision, shall be provided and communicated to you in writing within 60 days after receipt of a request for review unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than the 120 days after receipt of a request for review.

Submit written appeals to:

Vision Service Plan
Attention: Complaints and Appeals Unit
P.O. Box 997105
Sacramento, CA 95899-7105

You must submit your appeal within 180 days from receipt of the denial or you waive your right to request a review of the denied claim.

Refer to the "Claims" section at the beginning of this book for additional information about denied claims and what to expect from the Plan.

Appeals submitted after the deadline for submission will not be reviewed again and the preceding decision will stand.

Refund to the Plan for Overpayment of Benefits

Whenever payments have been made by the Plan in excess of the maximum amount payable under the Plan's provisions, Participants must reimburse the Plan for the amount paid in excess.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future benefits payable. The reductions will equal, but not exceed, the amount the Plan paid in excess of the amount it should have paid. The Plan may have other rights in addition to the right to reduce future benefits.

Recovery of Third Party Liability Claims

The Plan has the right to reimbursement from covered Associates, their Dependents, or another legally responsible person or entity for all benefits paid by the Plan that were associated with an Injury or Illness for which a third party is liable to the Participant. The Plan has the first priority right to reimbursement from any insurance coverage, including recovery from Uninsured or Underinsured Motorists coverage, judgment, settlement or otherwise. This right to reimbursement remains in effect whether such payment satisfies, in full or in part, the Participant's loss (i.e., regardless of whether the Participant has been "made whole" by the payment) or regardless of how a recovery is characterized. The reimbursement to the Plan shall not be reduced due to the fees or expenses of legal counsel retained by the Participant.

If the Participant or any other person or organization that was paid does not promptly reimburse the full amount, the Plan may reduce the amount of any future payable benefits. Participants have the same obligations as listed under the "Subrogation" section of this SPD.

Claims

Filing a Claim

Although VSP has a very large nationwide network of participating doctors, one may not be located near you or you may simply prefer to use another provider. If you wish to see a doctor that is not part of the VSP network, VSP will reimburse you up to the amount shown in the Covered Services overview, less any applicable Copayments.

You will need to pay the entire bill for the services received and then mail the following information to VSP:

- The doctor's bill, including a detailed list of the services received.
- The covered Associate's name, address and phone number.
- The Associate's Social Security number (all claims are filed under the Associate's Social Security number.)
- The name of the Associate's employer (Circuit City Stores, Inc.)
- The patient's name, date of birth, address and phone number.
- The relationship of the patient to the Associate (such as "self", "spouse", "child", etc.).

Claims must be filed with VSP within six months after services are received. Please keep a copy of the information and send the originals to:

Vision Service Plan
Attention: Out-Of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Only claims submitted within six months following the date of service will be accepted.

Payment of Claims

After VSP receives complete claim information, payment will be made to the appropriate payee:

- Directly to the VSP provider; or
- Directly to the Participant for reimbursements of qualified payments made by the Participant.

Benefits for covered Dependents after the covered Associate's death will be paid to one of the following:

- The surviving spouse;
- The Dependent child who is not a minor, if there is no surviving spouse;
- A Hospital or a person who makes charges to Dependents for services covered under this Plan; or
- The legal guardian of the Dependent.

If Your Claim Is Denied

You will receive a written notice of the payment/denial of your claim and the reason(s) for the denial from VSP. This notification will be sent to you within 90 days of the date that VSP receives your claim. If needed, this period may be extended for up to 90 additional days for a benefits determination.

Filing an Appeal

Within 60 days after receipt of such notice, you may make a written request for review of such denial, by addressing such request to the Plan administrator. You may state the reasons you believe that the denial of the claim was in error and provide any pertinent documents, which you wish to be reviewed. VSP will review the claim, the pertinent documents, and any statements, documents, or written arguments in support of the claim. You may appear personally

Laser Corrective Surgery

As a VSP member, you may also receive discounted fees for laser corrective surgery through a VSP network doctor. This program includes a complimentary screening and consultation on the benefits and risks of laser vision correction. Your VSP doctor will also work with you to make arrangements with participating laser surgeons and centers.

Post-procedure care will be coordinated between your VSP eye doctor and VSP laser surgeon.

Exclusions

The Vision Care Plan is designed to cover visual needs rather than cosmetic eyewear. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional cost for the options:

- Blended lenses;
- Coating of a lens or lenses, except for anti-reflective coating;
- Color coating;
- Mirror coating;
- Cosmetic lenses;
- Laminating of a lens or lenses;
- Oversized lenses;
- Progressive multi-focal lenses;
- Photochromatic lenses; tinted lenses (except pink #1 and pink #2).
- Ultraviolet (UV) protected lenses; or
- A frame that costs more than the Plan allowance;
- Contact lenses (except as noted elsewhere);
- Certain limitations on low vision care.

There is no coverage for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.38 diopter power); or two pairs of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eye wear required by an employer as a condition of employment.

VSP Value-Added Program

Each Covered Member is entitled to receive a discount toward the purchase of additional complete pairs of prescription glasses (lenses, lens options and frames). Also, Covered Members are entitled to receive a 15% discount off the cost of your contact lens exam (fitting and evaluation). Contacts are provided at the doctor's Reasonable and Customary Charges. Discounts are available from the same VSP network doctor who performs the eye exam within the last 12 months. Covered Members can also receive a 20% discount on non-prescription sunglasses, as well as value-added discounts from any VSP doctor within 12 months of last covered eye exam.

When Payments are Made

STD payments are made on regularly scheduled pay cycles and in most cases will be delivered to your work location or through direct deposit. If a paycheck is cut off cycle, then your paycheck will be sent to your home address, regardless if you have direct deposit.

It is very important to keep *YOUR* contact information up to date!
Update your name and other personal information by logging on to www.mycircuitcityhr.com or by calling the Associate Service Center at (800) 288-8353.

Your STD payments will be reduced by any payments you are entitled to receive from Workers' Compensation, Social Security, state Disability, and any other applicable employment-related benefits.

Workers' Compensation

Your STD payments from Circuit City will be reduced by Workers' Compensation benefits.

- If your weekly Workers' Compensation benefits are greater than or equal to your weekly Circuit City STD payments, then you will not receive any STD payments from Circuit City.
- If your weekly Workers' Compensation benefits are less than your weekly Circuit City STD payments, then Circuit City will pay you the difference between the two plans.

Workers' Compensation payments will be paid to you directly from the Workers' Compensation carrier, separate from your STD payments which are paid by Circuit City Stores, Inc.

State Disability

Only Associates who work for Circuit City in New York, New Jersey, Rhode Island, Hawaii and California may qualify to receive state Disability benefits and Circuit City STD payments. You are responsible for completing and filing any state Disability forms. Your STD payments may be reduced by the amount of the state Disability benefits.

Exclusions

STD payments will not be made for absences due to Medical Conditions that are:

- Intentionally self-inflicted
- Related to elective cosmetic surgery or treatment
- Related to a second absence for substance abuse*
- Related to illegal drug use
- Related to transsexual surgery, including intersex surgery (transsexual operations) or resulting medical conditions and/or sexual dysfunctions
- A result of work for pay or profit other than as an Associate of Circuit City Stores, Inc.
- Due to voluntary participation in unlawful acts
- Due to war, declared or undeclared, or any act of war or active participation in a riot

**STD payments for substance abuse, not including illegal drug use, are applicable for one STD leave of absence only.*

Underpayment of Benefits

If your STD payments are reduced because of other Disability payments and later it is determined that you are not eligible for payments from any other plan, you will receive the amount by which your STD payments were reduced. In this case, notify the Associate Service Center and provide proof that you did not receive payments from another plan(s).